ONE HUNDRED TENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

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MEMORANDUM

May 2, 2007

To: Representative Elijah E. Cummings

Fr: Oversight and Government Reform Committee Majority Staff

Re: Analysis of Alterations of the *Guide to Children's Dental Care in Medicaid.*

Executive Summary

In response to the major problems in low-income children's access to dental services identified by many public and private groups, the Centers for Medicare and Medicaid Services (CMS) issued a contract to the American Academy of Pediatric Dentistry (AAPD) to update a twenty-year-old guide to Medicaid and pediatric dentistry.[1] The AAPD delivered a draft of the updated guide to CMS in November of 2001.[2]

CMS did not publish the updated guide until October 2004,[3] almost three years after the draft was delivered. Between the time it was submitted and its eventual publication, the draft was significantly changed, with major portions deleted. It is not clear who within CMS, the Department of Health and Human Services (HHS), or the Office of Management and Budget (OMB) made these changes.

The changes are much more than simple editing.

- Data about extent of the problem of lack of access to dental services for children on Medicaid were deleted.

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1 Centers for Medicare and Medicaid, *Guide to Children's Dental Care in Medicaid* (October 2004), p. i, available at http://www.cms.hhs.gov/MedicaidDentalCoverage/Downloads/dentalguide.pdf (Last accessed on April 29, 2007. **[Hereinafter "Published Guide."]**

2 American Academy of Pediatric Dentistry, *A Guide to Children's Dental Care in Medicaid/EPSDT* (unpublished manuscript dated November 2001) **[Hereinafter "Original Draft."]**

3 Published Guide, title page.

- Statements regarding the legal responsibility of federal and state government to ensure that low-income children receive dental care were deleted.
- Recommendations about state oversight of the dental services of Medicaid managed care organizations were deleted.
- All references to Medicaid reimbursement and payment policies for dental services for children were deleted.

The resulting document stands in stark contrast to reviews by the Government Accountability Office[4], the HHS Inspector General[5], the Surgeon General[6], and CMS itself.[7] All of these analyses identified major failures in access to dental services for children on Medicaid. They also identified low Medicaid reimbursement rates for dentistry as a significant barrier to ensuring adequate access to dental care for children.

The extreme editing of the draft appears to represent a calculated effort by CMS, HHS, and/or OMB to hide from public scrutiny the many failings of federal and state oversight of the Medicaid program, including the systemic lack of oral health services for children and widespread violations of the Medicaid statute. The *Guide to Children's Dental Care in Medicaid*, as published by CMS, still includes some useful practice information for dental professionals. But all references to ongoing problems of access for Medicaid children, the repeated deficiencies in the administration of the program, and policy analyses that suggest avenues for improvement were deleted. In many respects, this re-writing calls to mind the earlier changes made to the document, "The National Healthcare Disparities Report."[8]

By the absence of any statements to the contrary, a reader of the Published Guide could come away with the impression that the Medicaid program is delivering dental services to poor children efficiently and well. By virtually all other accounts, it is not.

Introduction

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4 United States General Accounting Office, *Oral health: dental disease is a chronic problem among low-income populations* (April 12, 2000) (GAO/HEHS-00-72); United States General Accounting Office, *Oral health: factors contributing to low use of dental services by low-income populations* (Sept. 2000) (GAO/HEHS-00-149); U.S. Surgeon General, *Oral Health in America: A Report of the Surgeon General* (September 2000), available at http://www2.nidcr.nih.gov/sgr/sgrohweb/home.htm#foreword (last accessed April 29, 2007).

5 Health and Human Services Inspector General, *Children's Dental Services under Medicaid: Access and Utilization* (April 1996), available at http://oig.hhs.gov/oei/reports/oei-09-93-00240.pdf.

6 U.S. Surgeon General, *Oral Health in America: A Report of the Surgeon General* (September 2000), available at http://www2.nidcr.nih.gov/sgr/sgrohweb/home.htm#foreword (last accessed April 29, 2007).

7 CMS, State Medicaid Director Letter #01-010, January 18, 2001, available at http://www.cms.hhs.gov/smdl/downloads/smd011801a.pdf (last accessed April 30, 2007).

8 Minority Staff, Government Reform Committee, U.S. House of Representatives, "Changes to the National Healthcare Disparities Report" (January 2004), available at http://oversight.house.gov/documents/20040901170729-77795.pdf (last accessed April 30, 2007).

Oral health services are a required benefit for children in the Medicaid program.[9] In the 1970s, the Centers for Medicare and Medicaid Services (then known as the Health Care Financing Administration) issued a publication entitled *A Guide to Dental Care: EPSDT/Medicaid.* The publication was widely requested and used.[10]

Over time, however, the publication became outdated.[11] CMS issued a contract to AAPD to revise and update the draft. AAPD is "the membership organization representing the specialty of pediatric dentistry," which is one of nine recognized specialties in dentistry.[12] Its members are dentists across the country and "serve as the primary contributors to professional education programs and scholarly works concerning dental care for children."[13]

A final draft of the updated guide (hereinafter referred to as the "Original Draft"), was delivered to CMS in November 2001.[14] The process that was used for the editing and revision of the Original Draft after its submission and the identity of the editor(s) is not known.

CMS published its revised version of the guide, "A Guide to Children's Dental Care in Medicaid" (hereinafter referred to as the "Published Guide"), in October 2004, nearly three years after receiving the Original Draft.[15] The Published Guide departs from the Original Draft in many ways, from small line edits to the omission of entire sections. The collective effect of these numerous changes is to remove or deflect virtually all comment about the actual workings of the Medicaid program, its legal responsibilities for oversight and enforcement of the law, and the barriers that low-income children face in getting dental services.

Findings

Changes Regarding the Extent of the Dental Care Crisis Facing Low-Income Children

The Original Draft included the following statements about the incidence and prevalence of oral health problems in America, all of which were missing from the Published Guide:

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9 Social Security Act, Sec. 1902 (a) (43) (codified as 42 USC 1396a (a) (43)) and Sec. 1905R (codified as 42 USC 1396d(r)).
10 Craig Palmer, "CMS Oral Health Guide for Children Updated," ADA News (Nov. 2, 2004), quoting CMS.
11 *Id.*
12 AAPD, "About AAPD: Mission and Vision," available at http://www.aapd.org/about/mission.asp (last accessed April 30, 2007).
13 *Id.*
14 Original Draft, title page.
15 Published Guide, title page.

- "[N]ational surveys and federal and state studies continue to demonstrate substantial disparities in both oral health and access to dental services."[16]
- "[L]ow-income children are much *more* likely to suffer this disease, but also are much *less* likely to obtain dental care."[17]
- "Three times more U.S. children are in need of dental services than medical services, and yet children with public insurance (Medicaid) are only one-quarter as likely to see a dentist as they are to see a physician."[18]
- "[O]nly a small percentage of children enrolled in Medicaid receive safe and effective preventive measures."[19]

In addition, a statement that originally said "access for those with Medicaid coverage remains a chronic problem"[20] was changed to read "access for low income children remains a challenge."[21]

The Published Guide contains no statements about the extent of the problem of unmet treatment needs among children in Medicaid. While it does include some statements about the relationship between low income levels and decayed teeth, these are derived from a broad population study. They draw no distinction between children in Medicaid and those who are privately insured or uninsured.[22]

Changes Regarding Legal Responsibility for Ensuring that Children in Medicaid Receive Dental Services

The Original Draft included several statements about the program's legal responsibility for ensuring that children in Medicaid receive dental services. All of the following statements were deleted from the Published Guide:

- "The Medicaid program is ultimately responsible for ensuring that the referred beneficiary receives a complete diagnostic evaluation and for developing quality assurance procedures to assure comprehensive care following referrals."[23]
- "State Medicaid programs are ultimately responsible for assuring that direct referrals are made in accordance with their respective dental periodicity schedules, that necessary follow-up for dental diagnostic and treatment services are made, and that children identified as needing such services get to dentists' offices or other suitable treatment facilities in a timely manner. Ideally, if initial screening providers are not able to arrange for referrals directly, they should inform the responsible program administrators or intermediaries (e.g., health

16 Original Draft, p. 1.
17 Original Draft, p. 2.
18 Original Draft, p. 4.
19 Original Draft, p. 14.
20 Original Draft, p. 5.
21 Published Guide, p. 4.
22 Published Guide, p. 2.
23 Original Draft, p. 14.

plans) who then have the responsibility to see that necessary referrals are arranged and that care is initiated in a timely manner."[24]

- "Federal Medicaid law provides a child-specific standard for 'medical necessity' that applies to any service provided to an individual under the age of 21, including dental care, and emphasizes promotion of preventive services and good health outcomes, including dental health outcome...Because Medicaid is a state-administered program, it is the state Medicaid agency that ultimately makes medical necessity determinations, consistent with the broad federal framework for such determinations at 42 CFR 440.230."[25]
- "Medical necessity for purposes of EPSDT recipients must be determined on a case-by-case basis."[26]
- "While a state may set *tentative* limits on EPSDT dental services, it may not set flat or arbitrary limits on the amount, duration or scope of services."[27]
- "A state may place a tentative limit on services and require additional services to be prior authorized or may use certain utilization controls, such as prior authorization or second opinions, but these utilization controls may not impede the delivery of needed services."[28]

The Original Draft also included the following statement:

> "Although Medicaid regulation and policy do not require oral screenings as part of a general health screenings, oral screenings are strongly encouraged when children present for general health screenings...Screening is particularly important for infants and very young children..."[29]

In the Published Guide, this statement was reduced to the following passage:

> "Oral screening services are not required for Medicaid children. However, oral screenings may be considered part of comprehensive health screenings for infants and young children."[30]

The Original Draft contained 4 appendices:

> Appendix A: Clinical Issues
> Appendix B: AAPD Model Dental Benefits Statement and List of Procedures
> Appendix C: AAP/Towers Perrin Actuarial Estimates of SCHIP Costs Services

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24 Original Draft, p. 19.
25 Original Draft. p. 12.
26 Original Draft. p. 12.
27 Original Draft. p. 12.
28 Original Draft. p. 12.
29 Original Draft, p. 17.
30 Published Guide, p. 8.

Appendix D: Policy Issues in the Delivery of Dental Services to Medicaid Children and their Families

The Published Guide ends with Appendix B.

Appendix C, the Towers Perrin actuarial estimates, was deleted in its entirety. This appendix included an estimate of mean Per Member per Month dental care costs for Medicaid beneficiaries age 0-20.

Appendix D, a 20-page compendium on policy issues and the delivery of dental services to Medicaid children and their families, was deleted in its entirety. This appendix had been developed by an advisory group to CMS, the Medicaid Maternal and Child Health Technical Advisory Group, which included among its members several state Medicaid directors. This appendix included frequently asked questions and answers about Medicaid policy, ranging from the frequency of children's dental services required by federal law to time limits for submitting claims.

Deletions of these appendices provide further evidence that the Original Draft was heavily edited to provide little or no policy guidance.

Changes Regarding Dental Services for Children in Medicaid Managed Care Organizations

Medicaid services for low-income children are largely delivered through managed care organizations.[31] The Original Draft included several statements about dental services for children in Medicaid Managed Care Organizations. All of the statements that follow were deleted from the published version of the Guide.

- "If responsibilities are contracted to commercial third parties [sic] health or dental plans, preference should be given to plans that have demonstrated good working relationships with dental providers as evidenced by robust provider networks."[32]
- "Developing strong contracts is essential if responsibilities for administering children's benefits are to be delegated to third-party carriers or managed care organizations. Model contract provisions for contracting pediatric dental benefits under Medicaid have been developed by workers at George Washington University under a contract with the Centers for Disease Control and Prevention, and are available on the Internet at www.gwu.edu/~chsrp/sps/dental/intro.html."[33]
- "Equally critical, is a process to monitor program performance and enforce

31 Kaiser Family Foundation State Health Facts, "Medicaid Managed Care Enrollees as a Percentage of State Medicaid Enrollees as of June 2005," available at http://www.statehealthfacts.org (last accessed Apr. 30, 2007).
32 Original Draft, p. 21.
33 Original Draft, p. 22.

contract provisions to ensure accountability and provision of services needed by children covered by Medicaid."[34]

As a result of these deletions, the Published Guide contains no information or guidance regarding the creation and enforcement of managed care contracts.

Changes Regarding Medicaid Reimbursement for Dental Services to Children

The most substantive changes between the Original Draft and the Published Guide were to provisions that addressed the adequacy of state Medicaid reimbursement for dental services to children. Each state makes its own decision about the amount it will pay for these services to children. The federal statute places no upper limit on the amount that dental professionals may be paid. While there is no quantitative minimum payment required under federal law, states must ensure that rates "are sufficient to enlist enough providers so that ... care and services are available [under Medicaid] to the extent that [they] are available to the general population in the geographic area."[35] CMS has previously advised states that "significant shortfalls in beneficiary receipt of dental services, together with evidence that Medicaid reimbursement rates that fall below the 50th percentile of providers' fees in the marketplace, create a presumption of statutory noncompliance."[36]

A seven page section of the Original Draft on "Program Financing and Payments," which ran from page 23 through page 30 of the draft, was deleted. This section of the Original Draft discussed historical analyses of the inadequacy of state Medicaid payments for children's dental services, two sets of professional actuarial estimates of necessary funding levels to ensure that children get such services, a GAO study comparing payment policy across the states and with the prevailing market rates, and different models of rate adjustment. The Published Guide includes none of the above material. Indeed, the words "reimburse" or "reimbursement" appear only once (in Appendix A, "clinical issues," when referring to "communicative (non-aversive) techniques").[37]

The Original Draft included the following statements about the adequacy of state Medicaid reimbursement for dental services to children. All of them were deleted from the Published Guide:

- "Except for a few states that have made substantial recent changes, Medicaid funding and reimbursement levels have been widely regarded as a key factor in low participation by dentists."[38]

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34 Original Draft. p. 22.
35 Social Security Act, Sec. 1902(a) (30) (A) (codified at 42 USC 1396a (a) (30) (A)).
36 CMS, *op. cit.*, n. 7.
37 Published Guide, Appendix A, p. 19.
38 Original Draft, p. 23.

- "[A] substantial gap in funding levels exists in most states between current Medicaid dental program allocations and market-based requirements."[39]
- "[T]he U.S. General Accounting Office (GAO) noted in April 2000 that the primary reason cited by dentists for not treating more Medicaid patients was 'payment rates are too low.'"[40]
- "On average, the mean Medicaid fees for all state programs were found to be equal to or slightly greater than the 10th percentile of fees charged by U.S. dentists for three of 15 procedures (new and periodic examinations and fluoride applications) selected for the GAO survey. That is to say that only about 10 percent of dentists would view the Medicaid rates as comparable to their usual fees. Mean Medicaid reimbursement rates for the other 12 procedures were *less than* the fees routinely charged by even the lowest 10 percent of dental providers, oftentimes by a considerable margin. Thus, it is not surprising from an economic perspective that, at the time of the GAO's survey, 10 percent of dentists or less were 'meaningful' participants in most state Medicaid programs."[41]
- "Recent experience in several states (e.g., Georgia, Indiana, Michigan and South Carolina) suggests that raising reimbursement rate limits to levels that approximate the 75th percentile of prevailing fees in the state can significantly increase access and utilization of dental services by Medicaid-eligible children and participation by dentists in Medicaid..."[42]
- "The Medicaid rates average 56 percent of the respective average fees charged by dentists. Dentists' overhead generally is reported to be in the range of 60-70 percent of practice charges, exclusive of dentist compensation. Reimbursements below this range may not cover the costs of providing services and thus are not likely to be viewed as positive incentives for dentist participation."[43]
- "Historically, Medicaid programs have not adjusted reimbursement rates on a regular (e.g., annual) basis, contributing to Medicaid reimbursement schedules that fall further and further outside market conditions over time."[44]

The Published Guide also omitted two actuarial estimates of Medicaid funding levels necessary to provide adequate dental services to children. One of these estimates was done by Towers Perrin for the American Academy of Pediatrics.[45] The other was done by PriceWaterhouseCoopers for the Reforming States Group (with support from the Milbank Memorial Fund).[46] Although not directly comparable for design reasons, both studies produced estimates that are "multiples of current [per-child] funding levels in Medicaid dental programs."[47] The Original Guide notes that these actuarial estimates are necessary for sound reimbursement policy because generally available data focus on care

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39 Original Draft, p. 25.
40 Original Draft, p. 25.
41 Original Draft, pp. 25-26.
42 Original Draft, p. 26.
43 Original Draft, p. 26.
44 Original Draft, p. 28.
45 Original Draft, pp. 23-24.
46 Original Draft, p. 24.
47 Original Draft, p. 25.

provided to middle- and upper-income households and do not account for the severity of need of children enrolled in Medicaid.[48]

Changes Regarding General Financing Considerations for Medicaid Children's Dental Program Improvements

At the end of the section on "Program Financing and Payments," the Original Draft drew a number of conclusions. All of these passages were deleted from the Published Guide:

> "**Improvements Will Cost More** – Developing and sustaining an effective, market-based dental care system for underserved Medicaid populations may require the commitment of considerably more financial resources than may currently be allocated because:
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> - More children will be served and have more of their treatment needs met, thereby increasing expenditures for dental treatments.
> - New and expanded systems capacity expenditures may increase as new or improved support functions are put on line (e.g., information systems, provider training, disease management, care coordination, outreach, and safety net improvements).
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> **"Ongoing Costs will be less than Initial Costs** - Expenditures usually will be higher initially than after the system has stabilized. This 'front-loading' arises from pent-up demand and market-based purchasing adjustments on the treatment side and from initial capital costs for public health and systems capacity development. As children receive care, unmet need should decline and ongoing 'maintenance' level costs should be less than initial costs.
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> **"Proportionality** - The costs of market-based purchasing of dental services will continue to be very modest relative to total state Medicaid expenditures because current Medicaid expenditures for dental services comprise such a small portion of total program expenditures. Therefore, Medicaid dental program improvements will require significant increases over current spending levels on dental programs, but relatively little increase in overall public spending.
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> **"Potential Savings and Offsets** - Dental program improvements can be expected to yield significant savings in treatment costs on an individual level – i.e., on average, ongoing treatment costs per individual to maintain oral health will be less over time. These savings at the individual level will accrue from reducing disease burden (and need for dental treatment) and tailoring dental prevention and treatment to levels of risk. This is particularly likely for very young children (i.e., the 5 percent of children with catastrophic treatment needs that often require costly hospital services in addition to significant dental treatment costs and account for approximately 30

48 Original Draft, p. 23.

percent of typical Medicaid dental program expenditures). Savings for these high-needs children also could be achieved by having some children treated with the aid of sedation, when appropriate, rather than general anesthesia. However, many state Medicaid programs do not reimburse or reimburse inadequately for sedation services.

"Similarly, enhancing private dentists' participation should reduce, over time, the overall need for total investments in 'safety-net' clinic capacity. Nonetheless, enhancements of safety net facilities will continue to be needed in areas where there are no readily accessible providers. Engaging the capacity of private-sector dentists while targeting public health care infrastructure funding to dental health professional shortage areas will maximize efficiency while strategically using public funds to supplement 'gaps' in the private sector delivery system.

"Preliminary evidence for these projections comes from innovative programs implemented for Medicaid and low- income beneficiaries in Michigan and western Pennsylvania that engaged commercial dental plans with adequate networks and devoted funding levels that allowed purchasing of dental services at competitive market rates. Analyses of these programs conducted by university-based experts have demonstrated significant successes in relatively short time periods. These model programs have demonstrated substantial increases in individuals with a regular source of care, reductions in unmet treatment needs, increases in provider participation and geographic access, utilization patterns that stabilized per-enrollee costs, and high degrees of provider and enrollee satisfaction."[49]

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49 Original draft, pp. 28-29 (internal citations omitted).